Form Approved OMB No. 0920-0278 Exp. Date 05/31/2007 CDC 64.136

FORM **NHAMCS-100(ED)**
(8-1-2005)

U.S. DEPARTMENT OF COMMERCE
Economics and Statistics Administration
U.S. CENSUS BUREAU
ACTING AS DATA COLLECTION AGENT FOR THE
U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
National Center for Health Statistics

NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY
2006 EMERGENCY DEPARTMENT PATIENT RECORD

PATIENT RECORD NO.:

PATIENT'S NAME:

NHAMCS-100(ED) (8-1-2005)

1. PATIENT INFORMATION

a. Date of visit — Month | Day | Year: 2006

b. ZIP code

c. Date of birth — Month | Day | Year

d. Time of day
(1) Arrival ___ ___ : ___ ___ ☐ AM ☐ PM ☐ Military
(2) Time seen by physician ___ ___ : ___ ___ ☐ AM ☐ PM ☐ Military
☐ Not seen by physician
(3) ED discharge ___ ___ : ___ ___ ☐ AM ☐ PM ☐ Military
Mark (X) if ED discharge is more than 24 hours from arrival. ☐

e. Patient residence
1 ☐ Private residence
2 ☐ Nursing home
3 ☐ Other institution
4 ☐ Other residence
5 ☐ Homeless
6 ☐ Unknown

f. Mode of arrival – *Mark (X) one.*
1 ☐ Ambulance (air/ground)
2 ☐ Public service (nonambulance, e.g., police, social services)
3 ☐ Walk-in
4 ☐ Unknown

g. Sex
1 ☐ Female
2 ☐ Male

h. Ethnicity
1 ☐ Hispanic or Latino
2 ☐ Not Hispanic or Latino

i. Race – *Mark (X) one or more.*
1 ☐ White
2 ☐ Black/ African American
3 ☐ Asian
4 ☐ Native Hawaiian/ Other Pacific Islander
5 ☐ American Indian/ Alaska Native

j. Expected source(s) of payment for this visit – *Mark (X) all that apply.*
1 ☐ Private insurance
2 ☐ Medicare
3 ☐ Medicaid/SCHIP
4 ☐ Worker's compensation
5 ☐ Self-pay
6 ☐ No charge/Charity
7 ☐ Other
8 ☐ Unknown

2. TRIAGE

a. Initial vital signs
(1) Temperature ☐ °C ☐ °F
(2) Pulse beats per minute
(3) Blood pressure ___ / ___
(4) Oriented X 3 — 1 ☐ Yes 2 ☐ No 3 ☐ Unknown

b. Immediacy with which patient should be seen
1 ☐ Immediate
2 ☐ 1-14 minutes
3 ☐ 15-60 minutes
4 ☐ >1 hour-2 hours
5 ☐ >2 hours-24 hours
6 ☐ No triage
7 ☐ Unknown

c. Presenting level of pain
1 ☐ None
2 ☐ Mild
3 ☐ Moderate
4 ☐ Severe
5 ☐ Unknown

3. PREVIOUS CARE

Has patient been:

a. Seen in this ED within the last 72 hours?
1 ☐ Yes
2 ☐ No
3 ☐ Unknown

b. Discharged from any hospital within the last 7 days?
1 ☐ Yes
2 ☐ No
3 ☐ Unknown

4. REASON FOR VISIT

a. Patient's complaint(s), symptom(s), or other reason(s) for this visit *Use patient's own words.*
(1) Most important:
(2) Other:
(3) Other:

b. Is this visit work related?
1 ☐ Yes
2 ☐ No
3 ☐ Unknown

5. INJURY/POISONING/ADVERSE EFFECT

a. Is this visit related to an injury, poisoning, or adverse effect of medical treatment?
1 ☐ Yes
2 ☐ No – *SKIP to item 6.*

b. Is this injury/ poisoning intentional?
1 ☐ Yes, self inflicted
2 ☐ Yes, assault
3 ☐ No, unintentional
4 ☐ Unknown

c. Cause of injury, poisoning, or adverse effect – *Describe the place and events that preceded the injury, poisoning, or adverse effect (e.g., allergy to penicillin, bee sting, pedestrian hit by car driven by drunk driver, spouse beaten with fists by spouse, heroin overdose, infected shunt, etc.).*

6. PHYSICIAN'S DIAGNOSIS FOR THIS VISIT

As specifically as possible, list diagnoses related to this visit including chronic conditions.

(1) Primary diagnosis:
(2) Other:
(3) Other:

7. DIAGNOSTIC/SCREENING SERVICES

Mark (X) all ***ordered*** *or* ***provided*** *at this visit.*

1 ☐ NONE

Blood tests:
2 ☐ CBC (complete blood count)
3 ☐ BUN/Creatinine
4 ☐ Cardiac enzymes
5 ☐ Electrolytes
6 ☐ Glucose

Other tests:
12 ☐ EKG/ECG
13 ☐ Cardiac monitor
14 ☐ Pulse oximetry ___ %
15 ☐ Pregnancy test
16 ☐ Urinalysis (UA)

8. PROCEDURES

Mark (X) all ***provided*** *at this visit. Exclude medications.*

1 ☐ NONE
2 ☐ Bladder catheter
3 ☐ CPR
4 ☐ Endotracheal intubation
5 ☐ IV fluids
6 ☐ Nebulizer therapy

9. MEDICATIONS & IMMUNIZATIONS

List up to 8 drugs given at this visit or prescribed at ED discharge. Include Rx and OTC drugs, immunizations, and anesthetics.

☐ NONE

	Given in ED	Rx at discharge
(1)	1 ☐	2 ☐
(2)	1 ☐	2 ☐
(3)	1 ☐	2 ☐

12. HOSPITAL ADMISSION

Complete if the patient was admitted to the hospital at this visit.

a. Admitted to:
- 1 ☐ Critical care unit
- 2 ☐ OR/Cath lab
- 3 ☐ Other bed/unit
- 4 ☐ Unknown

b. Hospital admission time

__ __ : __ __ ☐ AM ☐ PM ☐ Military

c. Hospital discharge date

Month	Day	Year
		2 0 0

d. Principal hospital discharge diagnosis

e. Hospital discharge status
- 1 ☐ Alive
- 2 ☐ Dead
- 3 ☐ Unknown

If this information is not available at time of abstraction, then complete the Hospital Admission Log.